Hon. Dr David Clark
Minister of Health
Private Bag 18888 – Parliament Building - Wellington 6160

95 Churchill Road
Judea – Tauranga 3110

Phone 021-1-30-95-84

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Sent via email – david.clark@parliament.govt.nz

incl. attachments: letter and redacted provisional opinion from HDC
spreadsheet response to provisional opinion
email exchange with HDC
Letter to Health Minister 27 March 2018
Court order against Bupa November 2017

An Open Letter of concern regarding The Health and Disability Commission

Dear Dr Clark,

I wrote to you on the 13th of September describing serious concerns with the Health and Disability Commission. You noted my comments and asked the Health Department to respond directly to me. They have failed to do so. I am now readdressing my concerns to you in this open letter and asking you to please take a personal interest in this matter.

It is now almost three years since I first complained to our regulatory authorities about the company Bupa and their St Kilda care home in Cambridge Waikato[1]. While in Bupa's care my mother suffered a cascade of abuse and medical mistreatment that lead to her painful death in February 2017. These failures in the provision of care, occurred throughout the period she was in Bupa's care and often were of a nature that shamefully must be called abusive.

During the past 34 months there has not once been a finding or appropriate comment regarding my complaints from any of these agencies. Why ?

The manner in which my complaints have been consistently mishandled should now raise questions at a ministerial level, as they continue to undermine confidence and cause concern.

Recent developments in August and September critically highlight this and bring the role of the Health and Disability Commission, as a regulating authority, once again into question.

For most New Zealanders, and particularly those with complaints regarding long term residential care, the Commission represents the ultimate agency to which they can appeal. It is essential that there exists broad public confidence regarding who's interests the Commission serves. However, based on my experience it certainly does not appear to be those of the New Zealand Health Consumer.

The purpose of the Health and Disability Commissioner is to promote and protect the rights of consumers as set out in the Code of Health and Disability Services Consumers' Rights. This includes resolving complaints in a fair, timely, and effective way.[2] Yet there has been nothing in the management of my complaints that could be described as fair, timely or effective.

Further, there is now a chronic and verifiable pattern of behaviour on the part of the Health and Disability Commission (HDC), that defeats their own core mission. This failure undermines confidence in our system and is nothing short of alarming. In the same way that complaints, such as mine, usually indicate a broader set of concerns within a care home, so it is likely that many New Zealanders have had similar experiences to mine when dealing with the HDC.

As set out below, HDC's conduct has been to ignore my complaints regarding the Waikato DHB while preparing to ameliorate Bupa's malfeasance.

I am going to focus on these two charges but in doing so it will be helpful to place them within a timeline of events. The chronology and supporting material that follows shows a disturbing bias to the commercial interests of Bupa. [In the later stages of my comment I reference the relevant part of the HDC provisional “information gathered” opinion and this is supplied for comparison].

1. In January 2017 I complained to the Ministry of Health about the mistreatment and abuse my mother was being subjected to at the Bupa St Kilda residential care home. This mistreatment and abuse had been chronic and often at the extreme range of such matters. It can be described as the denial of the necessities of life which in other circumstances would have likely proceeded to criminal charges.

2. The Ministry of Health referred my complaint to Waikato District Health Board (DHB) on or about the 17th of January 2017.

3. The investigation conducted by the DHB was grossly inadequate and inappropriate. It comprised of a one hour meeting on the 19th of January 2017 and a number of subsequent telephone calls and emails. The meeting was attended by three senior Bupa managers and just one member of the DHB; no notes were taken at the meeting. Over the next few weeks, despite Bupa changing their explanations several times and those excuses being contradictory & illogical, the DHB accepted Bupa's revisions without question or challenge.

4. There is compelling evidence of malfeasance on the part of both Bupa and WDHB during this period. This includes attempts by Bupa to have me agree to conditions and medical interventions on behalf of my mother. All these demands by Bupa were for Bupa's convenience and purpose, they were illegal and in direct breach of New Zealand Law. There are several independent sources of evidence supporting this statement of complaint. These include verbatim notes taken by DHB staff and correspondence between Bupa and the DHB where Bupa confirm their requirements as non negotiable conditions (both obtained under OIA).

5. In February 2017, shortly after my mother succumbed to Bupa's mistreatment and died, the DHB concluded their investigation. The DHB stated they were satisfied Bupa had apologised and would take appropriate corrective action. This was was informed to me by letter and like wise to Bupa in what was a collegial and empathetic, if mildly rebuking, correspondence. Both letters were deeply offensive to me. No meaningful consequence for Bupa followed. Why ?

6. I referred this matter to The Health and Disability Commission at this time.

7. In April 2017 finding the DHB's actions unacceptable and frustrated by the slow response from the Health and Disability Commissioner I undertook legal action establishing that Bupa breached NZ consumer law. My motivation was not financial but to establish a credible, independent review of Bupa's actions and statements during this period.

8. In November 2017 that review became available when Bupa were found to have made false and misleading representations and breached, on multiple occasions, New Zealand law. Bupa were ordered to pay $10,000 in recognition of this. The findings from this adjudication stand in stark contrast with the DHB's earlier actions.

9. The findings of this legal review are irreconcilable with the earlier actions of the DHB. While I acknowledge that the legal test applied may not be those that should have been applied by the DHB they are, in the majority of instances, sufficiently similar to illustrate the inadequacy of the DHB's actions.

10. At the time it was self-evident that Bupa staff generally performed numerous procedures incorrectly and with poor or no corrective supervision. This lead to frequent, dangerous failures of care. It is reasonable to assume that there were many occasions that staff performed procedures (ineffectively) that they were neither qualified, trained or sufficiently experienced to perform. Bupa's concealment of this information from me formed part of a fabric of lies that the company told during and after the period they had responsibility for the care for my mother.

11. In early 2018 I received documents I had requested from the DHB under the Official Information Act. I revisited this matter and complained to the HDC about the DHB.

12. On the 26th of March 2018 I met, at your suggestion, with senior managers at the Ministry of Health. I wrote to you the next day with a detailed account of that meeting. I have attached this letter to assist you and show how little has changed in the intervening 18 months. It establishes that the Ministry of Health and your office knew and understood the seriousness of my complaints against the DHB and their dereliction of duty.

13. Following the above meeting (I do not know if these events are connected) in response to my complaint, HDC referred me back to the DHB. In May 2018 a meeting was convened at the DHB attended by the Interim Chief Executive of WDHB, Mr Derek Wright, Jessica Wilson, who is Head of Research at NZ Consumer Org., myself and others. At that meeting the DHB reluctantly agreed to ordered an unannounced audit of St Kilda.

14. That audit found ongoing problems similar to those I had complained about in 2016/17. This showed that the assurances that had been provided to me by the DHB had not been kept. The DHB misrepresent the audit findings in media statements. Why ? Bupa were again allowed to manage these problems internally without consequence or supervision from the DHB. Why?

15. The DHB were required to report the outcome of this to HDC - they misrepresented this to HDC. I wrote to HDC in 2018 drawing their attention to this - HDC have yet to respond. Why ? This complaint against the DHB was last raised with HDC in September this year who again undertook to comeback to me regarding this. I am still waiting.

<u>HDC's management of my complaint against Bupa.</u>

16. There have been multiple delays and errors on the part of the HDC in their handling of my complaints against Bupa. These include (but are not limited to) misleading statements about the commencement of their investigation, taking an inappropriately narrow view of the scope of my complaints and the replacement of an expert advisor.

17. In April 2018, HDC appointed an expert advisor (Mrs RN Sherriff) to review my complaints and provide a report to HDC. My request for a copy of this report was declined by HDC and I was obliged to use OIA to obtain it. Why ?

18. HDC continued to frustrate my access to this report and I was obliged to refer the matter to the Ombudsman. Why ? The Ombudsman found in my favour.

19. Mrs RN Sherriff's report, when finally supplied, was found to have many errors of fact. It was demonstrably bias in favour of Bupa. I wrote to HDC, several times, questioning the impartiality of the author and her report. I asked if she had any ties to Bupa. I received written assurances from HDC that they had conducted the necessary due diligence consistent with this appointment. In that correspondence HDC said:

" [HDC] had established that RN Sherriff did not have any conflicts of interest before we engaged her services to provide advice on this complaint". [3]

My research revealed that this was not correct and indeed Mrs Sherriff was heavily conflicted in her relationships with Bupa. These conflicts included (but were not limited to):

- Being a fellow director alongside the Managing Director of Bupa in a separate company in which Bupa are by far the largest client.[4]

- Being a director and owner of another company supplying product and services to Bupa.[5]
- Additionally, one might reasonably expect that Mrs Sherriff was unqualified to provide any advice on my complaint due to her own troubling history as a Care Home owner. Her business had failed repeated Ministry of Health audits in recent years. Astonishingly, her business, which she both owns and manages had failed those audits in similar areas to my complaints.

  HDC knew or should have known all this.

20. Late on a Friday (26/10/18) The Associate Commissioner Investigations at HDC, Mr Mark Treleaven, telephoned me in the evening. He said he had a prepared statement and wanted to read it to me prior to releasing it to the media. That statement follows:

    "The matters raised have only recently been brought to our attention and we place a high value on our independence and impartiality. We take any perception of conflict of interest in relation to our expert advisors extremely seriously. We have reviewed the evidence in this case and we have seen no evidence of bias. None the less given some of the concerns raised we will be seeking new advice on this matter."

21. I drew Mr Treleaven's attention to the errors in his statement. Ms Sherriff's report was indeed bias and had many errors of fact and false content. Further I had alerted HDC to my increasing concerns in June, July and September that year.

22. Despite this, the Commission released their statement to the media and simply appointed a replacement for Mrs Sherriff. They then refused to discuss this matter further with me. Why ?

23. It should be noted that prior to this action HDC held the report for several months, supplied it to Bupa, were clearly proceeding with it's advice and must have considered it to have stated they found it to be without bias or errors. Had their actions in trying to obstruct my access to this report been successful, it would have lead to their opinion and decision being based on the advice from Mrs Sherriff.

24. HDC position on this matter appears to be that they appointed Mrs Sherriff not knowing her multiple connections and ties to Bupa or any of the other conflicts and disqualifying problems she had. They were happy to receive Mrs Sherriff's report and recommendations and had no difficulty with it. They would have been happy to proceed had I not objected to those conflicts of interest. Further, HDC when asked, were content to deny any conflicts of interest and affirm her as a qualified and impeccable expert advisor. However, having now replaced Mrs Sherriff they believe any taint that might be associated from this matter to the HDC investigation, opinion and decision has been expunged.

Process Conditions and Procedure

25. In August this year I was advised that HDC had reached a provisional opinion and was in the process of fixing their final decision and report.

26. Both parties, that is Bupa and myself, have been invited to comment. Though not expressly stated it is assumed that such comments might influence the final opinion / report.

27. However there is a clear disparity between the insight and opportunity provided to Bupa when compared to myself. Bupa had been provided the full report including information gathered during investigation, provisional opinion, proposed recommendations and proposed follow up actions. I, on the other hand, was supplied only a redacted version of the "information gathered during investigation" section.

28. To say this is unbalanced is an understatement. Yet HDC justify this under the spurious claims of "natural justice". There seems absolutely no consideration as to what constitutes natural justice for me.

29. While Bupa are provided the evidence being considered, they are also provided an insight into how the Deputy Commissioner is interpreting that evidence. Accordingly, they are provided a distinct advantage into how to influence the provisional opinion, which will become the final opinion and HDC final report. I am denied all this. Additionally Bupa is able to see how their submission was received and what influence it had. I am denied this also.

30. I, the aggrieved party, see only the evidence that the Commission is considering. In contrast to Bupa I do not get to see how that evidence is being interpreted nor what influence, if any, my submissions has on the final decision. HDC have made no effort to explain how this is balanced or provides me with natural justice.

31. HDC appear to have a dull awareness as to how unfair this is because getting them to clearly set out their practice has been far more difficult than it needed to be. I have enclosed with this letter the recent email transactions between HDC and myself to illustrate this.

32. I requested a copy of the full provisional report under the OIA. After I had made this request HDC informed me that they advised Bupa that I had made this request. I was also told by HDC that Bupa's lawyers had made a submission on my OIA request. It is unlikely this is a supportive measure by Bupa. I am told by HDC that I am not allowed to see that legal submission. You will understand if I observe that information appears to flow more freely in one direction than the other.

33. I am not allowed, as a natural right, to see the full provisional report. Further when I request that right under the Official Information Act, Bupa informed HDC that I have made that request. Bupa's lawyers then made a submissions to HDC (on my request) and I am not allowed to see that either.

There is the suggestion (see attached email exchange) that it is Bupa that will make the decision on whether I see the provisional report ! I have asked HDC if this is likely to be the case and they have not responded !

34. Placing this Kafkaesque nonsense aside I will now come to the material HDC have provided me. This is the content they call the "information gathered during investigation" section of the provisional report. We might consider it the evidence.

Information and Evidence

35. I understand that the "material information" sent to me informs and supports the provisional opinion formed by the Deputy Commissioner, Mrs Wall at HDC. It is what she will use to base her final decision. The quality of any decision relies on the quality of the evidence that informs that decision.

36. It follows therefore that care should be exercised to ensure statements are as accurate and truthful as possible. Evidence should not be selectively presented to diminish or exaggerate. Which is why it is surprising to discover there are a number of statements concerning dates that are incorrect and suggest that they have been supplied by Bupa and not checked by HDC.

    For example (HDC83). It can not be true that wound evaluation was conducted on a weekly basis until the 30th of January given that my mother departed St Kilda on the 18th of that month and did not return.

37. In both presentation and content there are concerns that arise from reviewing this material. While the above example is relatively trivial, when considered along with the others errors it is collectively concerning. There are others examples that are far more consequential, some of which I will detail.

38. HDC have been highly selective in the incidents they have elected to represent. Many are not recorded. Further the information HDC have provided is often incomplete and/or presented in a manner that appears favourable to Bupa. This is often identified by what HDC have omitted to record. This is particularly so in instances where information, readily available to HDC, directly refutes what Bupa state. This is an omission of evidence.

39. For example in the incident on the 24th October (HDC 45 - 49) there is no mention that the call bell was discarded under the bed, making it impossible for my mother to call for assistance. The thin blanket that Mrs Baker claims was placed over my mother was only able to cover a portion of her upper body. While it may be difficult to convey how cold the room was (there had been a heavy frost that morning) an assessment of how long my mother was obliged to lie in a cold urine soaked bed could be made. It is possible to deduce from Bupa's statements, concerning when she was last attended and when I discovered her shivering and sobbing, that my mother spent between 4 to 5 hours in these conditions that morning. Additionally HDC's presentation of this incident does not record that both Bupa Managers were absent that day and no reply was made to my text messages of complaint.

There are several reason this additional information (in some form) is needed. Apart from showing it is being considered by HDC, it is important as it provides context and weight to what was taking place in Bupa during the chaotic periods I complained about. It provides a counterpoint to the increasingly casual, dismissive, ineffective and ultimately dishonest responses from Bupa at the time and balances their current dishonesty.

40. In another example of omissions the incident of wound care on the 14th/15th of January 2017 (HDC 86 to 90) HDC makes no reference to the photographic evidence that records the placement of the wound dressing. These photographs (recorded as the dressing was being removed) take the question of where the dressing was placed out of conjecture. The photographs establish beyond doubt that the adhesive dressing was placed directly onto raw, lymph exuding, flesh. They show other statements to be false.

    Bupa's admission (HDC 93) “that there are better ways of placing a dressing on the buttocks” is a gross understatement. There are no circumstances under which the placement of this dressing would be considered acceptable – even by unqualified staff. The absolute inappropriate application of adhesive material directly onto a large area of broken and raw skin was done knowing that my mother would be moved (rolled) from side to side throughout the night. Unlike how HDC describe the “likely” distress this caused (HDC90) we may be confident that movement during the night pulled this dressing causing direct, excruciating pain and discomfort.

41. Another substantial and troubling example where incidents are reported incorrectly are the events which took place on the 22nd of November (HDC 51 – 53) . What actually took place on this day, stands in such contrast to how it is presented by HDC, that the two accounts are unrecognisable as describing the same day.

    At 7.30am that morning I discovered that my mother's IDC was leaking. It was not until approximately 9.00pm that evening that a tortuously distressing episode concluded; and then only temporarily.

    For over 14 hours Bupa staff demonstrated a collective inability to provide the most basic care while misrepresenting the situation. Staff were without management for the entire day and it was chaotic. Throughout the day my mother was subjected to a succession of ineffective interventions by several nurses. All their efforts failed and for some reason not one of these nurses wanted to replace the catheter. I believe that individually and collectively all the nursing staff on duty that day engaged in a deceitful practice to conceal the truth and not provide information we were entitled to.

    Around noon a scheduled visit by the BUPA GP resulted in my mother being diagnosed with a suspected urinary tract infection. The doctor made that diagnosis on his observation of my mother's appearance. I asked but was never told why it took the staff until 8.00pm that night before the first dose of antibiotics was started.

    All day my mother's condition deteriorated, she was subjected to many changes of bed clothes and periods when she was exposure to urine. All this took place in a room with high temperature and humidity. I had installed a thermometer in an attempt to get Bupa

management to take the environmental issue in the room seriously. The recorded room temperature jumped a number of times and was well in excess of 30 degrees Celsius throughout the day.

By late afternoon on asking what was happening regarding the leaking catheter I was told the plan was to keep my mother dry as possible and pass this instruction over to the night staff.

This seemed to be a very poor plan. It meant prolonging and probably increasing my mother's discomfort and disruption throughout the night. Also, I could not understand why staff just didn't replace the catheter. I did not think this plan particularly well thought through or considerate to my mother's condition.

Mrs Baker was not answering her phone but I sent the following two text messages:

2016-11-22 18:44:02 Sent

I have concern for my mother's care this evening. Since 7.30 today staff have been unable to stop the IDC from leaking. Various RN staff have jiggled and tried to stop leakage. EACH time leakage is confirmed we are told that the plan is to continue to see if it has stopped Leaking. It has been leaking for almost 12 hours now and continues to leak. The plan has not changed as we go into evening. my mother is becoming wearied by this. Throughout the day I have been asking for this to be addressed. I have the feeling no one wants to own the problem !!!! Is what is being proposed (to allow this situation to continue over night medically correct?) Please call me on my mobile

2016-11-22 19:09:31 Sent

To provide/record additional observations. my mother has felt unwell all day. The GP charted antibiotic today for suspected UTI. The room uncomfortably hot 30c . my mother sleepy and at times distressed. This evening my mother becoming angry and frustrated. Our RN is telling us now that the plan to see a urinary specialist on Thursday !!! We feel extremely uninformed and abandoned. Please call me.

Neither of these messages were ever answered by Bupa Management.

The above communication is not referenced by HDC but it provides a contemporaneous account of this day that is far more accurate than what is formed by HDC presentation of information. (Further they provide strong evidence that addresses Bupa's false statements in HDC 76, 78, 69 and elsewhere)

It is reasonable to deduce that staff were having similar difficulty reaching Bupa management. No one seemed to be in charge and everyone was reluctant to talk with me. I made frequent requests to talk with a senior member of Bupa staff. These requests were not satisfied until at approximately 7.30pm when I was at last able to talk with the Clinical Manager by phone. This conversation took place as a conference call on the hospital

speaker phone with three members of staff present.

I explained the situation to the Clinical Manager and she instructed the staff present to replace the catheter.

A private phone conversation now took place between the Clinical Manager and one of the Nurses. I was not allowed to be present. There was no explanation offered as to why I was excluded from this part of the conversation. All Staff now left my mother's room without explanation.

At 8.55pm, almost an hour and a half later, Rose, a nurse who had not been on duty that day arrived. Rose assisted by another nurse now removed and replaced the IDC.

I was told that the reason for this delay was that Rose had been called in from her home especially to assist but not why this was needed. It should be noted that this directly contradicts the statements Bupa made (HDC 76). HDC make no comment on this.

Throughout the day the level of support and information had been astonishingly poor. There was a sense of desperation and visible lack of confidence with all the staff. As each intervention failed the nurses became less able to decide or communicate what the next action would be. At times there appeared disagreement among the nursing staff and I witnessed stressful conversations taking place that I could not hear. The next day on discovering the IDC still leaking my mother was sent to Waikato Hospital. There she was fitted with a new catheter and the problem was resolved. They found nothing wrong with my mother's bladder or IDC. She was discharged and return to St Kilda the same day.

Two days later my mother suffered a strong clonic seizure. She had no previous history of such events. I attribute the stress and conditions she was subjected to on the 22nd of November as contributing to, if not causing, this event.

Among the incidents HDC do not record there is no mention of this seizure or the events that surrounded or followed it.

42. The meeting held at Bupa on the 12th of January 2017 and briefly described (HDC 67 – 71) represents the single largest omission of evidence. As presented by HDC it is a failure to represent honestly and fully the evidence of Bupa's malfeasance. Not only do Bupa once again present a false narrative (to distract and misdirect) but evidence from an independent witness is entirely omitted by HDC.

43. (HDC 69) *"Bupa St Kilda stated that in light of the recommendation from the Urology Service in September 2016 that Mrs Love change to a suprapubic catheter, a meeting was arranged with Mr Love and Dr Larsen to discuss the potential benefit to Mrs Love's care by removing her IDC"*

44. There is nothing about the above statement that is correct. Everything in this statement is factually incorrect and designed to misrepresent the truth.

45. There was no recommendation from the Urology Service in September 2016 to change to a suprapubic catheter. Consultations with Urologists in October had looked at options and weighed the merits of each option. That is all. There was no mention during the meeting on the 12 of January 2017 regarding a suprapubic catheter. This matter had been settled some time earlier and Bupa had been informed of this decision. We understood that the procedure for SPC was not without surgical risks. A contraindication for such a procedure was lower abdominal scarring.

    My mother had undergone a full hysterectomy and was significantly scarred in the lower abdomen. Additionally, it was explained that risks of bowl perforation during surgery increased as a result of her general morbidity. There were a number of additional considerations, all contributed to making the decision to proceed with a SPC unattractive for my mother. She was very clear in not wishing to undergo this surgical procedure.

46. Furthermore, none of this diminishes the duty and responsibility Bupa had to safely and professionally manage the IDC. Had they done so, all these considerations become redundant.

47. Bupa did not arranged a meeting between Dr Larsen and myself to discuss the potential benefits of removing the IDC. At least not one that I was made aware of. Such a claim is illogical in the context of the 12th of January meeting. The meeting was represented to me as a six monthly review. I welcomed this opportunity to engage Bupa management with questions concerning recent care failures and other concerns. It was Dr Larsen's first day in this job – she started that morning.

    Though I did not expect this, I was not surprised that the first matter of business that morning was to secure my agreement to remove the IDC and use incontinence product. Bupa had made several representations to me along those lines in late November and December, talking about improved absorbency and manufacturers guarantees regarding such product's ability to take the urine away from skin.

    I was broadly against this approach because I had observed that when not enclosed in "product" my mother was far less troubled with thrush and other skin irritations. Exposure to greater circulating air and less humidity trapped around this part of her body promoted the healing of her skin. By late November / early December 2016 my mother was not wearing any enclosing product for these reasons. Finally, I was not convinced by the claims that "product" could be equivalent to a correctly functioning and well managed urinary catheter. I sought clinical advice and was encouraged to persevere with the IDC by "several" senior doctors.

    Prior to Christmas 2016 I sought advice around this issue again with the Medical Director of Waikato Hospital's Gerontology Service. I received clear and unequivocal advice, both verbally and in text, to retain the IDC. Indeed, my mother was discharged back to Bupa St Kilda on the 24th of December with prophylactic antibiotic charted to support this decision. This was designed to prevent UTI's in recognition that the IDC would be retained while her wounds healed.

HDC have chose to record none of this detail in the information gathered. They have available to them the written advice provided me – as did Bupa.

48. The intention of Bupa management during the meeting on the 12 of January was to gain permission to remove the IDC and manage my mother with incontinence product.

    Although Bupa's narrative attempts to suggest otherwise, Bupa's determined efforts were not based on consideration for my mother. Rather, their motivation was their realisation that they did not have the ability to manage her IDC. This meeting was contrived to achieve that, and only that solution to their problem. They sought to avoid having to admit their inability to meet their obligations to provide safe IDC care.

49. The meeting was combative and strained due to my refusal to acquiesce to what increasingly sounded like harassment from Bupa management. Finally Dr Larsen intervened to support me and what I was saying and to allow the meeting to move on to other issues. Bupa management appeared frustrated and angry at this. When the meeting did moved on from this issue and I attempted to ask questions regarding the care of my mother and their management of the IDC, Bupa were unable to provide answers and appeared flummoxed and disorganised. They were dismissive of my questions and their inability to provide answers underscored how chaotic and disorganised their care and systems were.

50. This is what HDC own advocacy service had to say about this meeting:

    "I supported Mr Love at a meeting arranged by the St Kilda management and the facility's new general practitioner. Attempts to get resolution were unsuccessful, due to the management maintaining incontinence products would be better than catheter use for managing Mrs Love's condition. The doctor intervened to support Mr Love, saying management could make use of the Waikato Hospital incontinence team to train staff in catheter use, and that the treatment prescribed by the hospital specialist should not be deviated from without referral back to him.

    Bupa were unable to answer Mr Love's questions regarding a recent incident related to catheter care and record keeping. They admitted that their record keeping was unreliable and therefore meaningless.

    Mr Love's concern about the heat in his mother's room was not resolved. With management stating this was a common problem and that air conditioning in the corridors was designed to provide cooling in the rooms."

51. To underline the above statement; it is made by a person who is trained to provide a balance and unbiased understanding of what is being said. It is accurate and records what actually took place in that meeting. This independent account accompanied the original complaints to HDC. I therefore conclude HDC made a deliberate decision to disregard this independent witness account from their consideration of the 12th of January meeting in order to give emphasis to Bupa's version of events.

Conclusion

52. Throughout the time that my mother was a resident at Bupa St Kilda, Bupa management dealt with me dishonestly. As it became increasingly obvious that there were seriously failing in the care Bupa were providing, I asked, on multiple occasions, about the competency of staff. Bupa management were dishonest in their response to those questions. They were also at fault, perhaps criminally negligent, in how they responded to those failures. As the frequency and severity of Bupa's failures increased, my complaints were increasingly ignored by the company. Subsequently, their behaviour has consistently been to misdirect with statements such as made in HDC 70 which is a self evident nonsense and comes out of nowhere. The placement of a SPC is a surgical procedure not undertaken by Bupa but within a hospital setting and can only be performed with informed consent. Bupa's statement is simply intended to distract from their responsibility to provide care for a common nursing requirement – something they could not and did not provide.

53. During the period that Bupa were first responding to the DHB regarding my complaints they made several demonstrably false statements. Their first response to the Waikato DHB was to claim:

    "*their care of Mrs Love was appropriate to her needs and was consistent with expected nursing practice*"[6]

    Bupa then began a process of re-framing my complaints admitting they had made "some" mistakes and that I had "some" valid concerns. Bupa's response to emerging evidence has been to change their excuses repeatedly. What has been consistent, has been Bupa's attempts to minimise their managerial responsibility and diminish the seriousness of their negligence.

54. Bupa are a powerful multinational company which, as part of their Australasian Group, are the largest provider of residential care homes throughout New Zealand. In Australia they are likewise the single largest provider of this service. Bupa, in both countries are managed by the same people and under the same share corporate structure. In all practical considerations they are the same company with the same operational and managerial personnel. It would be unlikely therefore that there is much material difference in the way this company operates in both countries.

    In Australia Bupa is being held to account for multiple breaches of care standards. More than a third of Bupa's Australian facilities are, or have been, deemed a 'serious risk' to residents – a worse record than any other provider[7]. Increasingly, questions are now focusing on the role of regulatory authorities in Australia that have allowed such a broad collapse of standards.

55. I had hoped that this corporate behaviour by Bupa might have been identified and deeply examined by HDC. I have reluctantly come to realise however that this will not be the case.

56. My comments here are far from comprehensive. Yet, they serve to illustrate the considerable difficulties that exist with the material HDC have used / will use to support their opinions, decisions and report.

    I appreciate that I have addressed the evidence being used to form the opinions and not the opinions of the Deputy Commissioner. (I of course am not allowed to know those yet). However, as I observed earlier, if the evidence that is available is not reported fully and honestly this does not bode well for what follows; and every New Zealander has an interest in that.

    "Full and honest" is not a term that can be applied to the material HDC are using to justify their provisional and (I presume) final decision.

57. A large part of the information I have set out here was provided to HDC when addressing the errors & omissions within the Sherriff Report. It is as if HDC reached a decision some time ago and are intent on discarding as much evidence as possible and cherry picking what remains so as to not embarrass that decision too much.

58. I have no confidence in the Health and Disability Commission. I do not believe they will provide a fair or impartial assessment of the complaints I have made about Bupa, or for that matter the DHB. This scepticism is based on how HDC have conducted their investigation of Bupa and my complaints to date. It is reaffirmed by HDC's selective representations of the evidence supporting my complaints, which invites questions as to whether it is designed to ameliorate Bupa's behaviour. I am of the opinion that this is the case and I do not wish to dignify what is now established in my mind as a sham.

59. I am also concerned that what I have set out above is evidence of a corruption in good practice that has taken place at HDC. For whatever reason this corruption occurred it has and will continue to affect the product of HDC. This is not in the interests of health consumers generally and can only lead to an unbalanced and flawed opinion in this and other matters.

60. The process that has brought us to this point has not been satisfactory. Nor does it promise to be any more satisfactory or fair in the future unless there is some intervention.

    Justice delayed is more that justice denied it is also opportunity for continuing unreasonable mistreatment of New Zealanders by a company that appears to face no meaningful consequence. If our regulatory authorities refuse to consider the malfeasance, or (either passively or actively) work to minimise, justify and excuse it, we lower our standards and put ourselves, as well as those we love, at risk .

It is my hope that in setting out my experience, that changes may yet occur that will allow us to avoid the worse cases that are presently being reported in Australia[8].

Again, in 34 months my multiple complaints about Bupa have remained either under investigation or inappropriately dismissed by those who should be rigorously championing these charges.

Such silence serves neither justice nor the safety of others in long term residential care. Further, such a vacuum, works only in the interest of the provider, while undermining confidence in how safety is provided to all health consumers.

Accordingly, I am respectfully asking that you now take a direct interest in this matter and the regulatory authorities that control the residential care industry.

Yours sincerely,

Robert M. Love.

Inc: HDC information gathered
Comparison Spreadsheet
Email exchange between HDC and myself
Letter to Health Minister 27 March 2018
Court Order against Bupa in November 2017.

1 I complained to the Ministry of Health (HealthCert) in December 2016 and January 2017. They referred my complaints to Waikato DHB in January. I complained to the Health and Disability Commission via their Advocacy Service in March 2017 . I added complaints about the DHB in early 2018 following the supply of internal documentation from the DHB under the Official Information Act.

2 https://www.hdc.org.nz/about-us/

3 Correspondence between HDC and myself held on file.

4 https://nzaca.org.nz/about/board-members/

5 https://www.careerforce.org.nz/people/rhonda-sherriff/

6 Internal DHB correspondence obtained under OIA

7 https://www.theguardian.com/australia-news/2019/sep/12/something-is-wrong-at-the-top-how-bupas-aged-care-homes-hit-rock-bottom

8 https://www.abc.net.au/news/2019-09-12/bupas-aged-care-homes-failing-standards-across/11507866